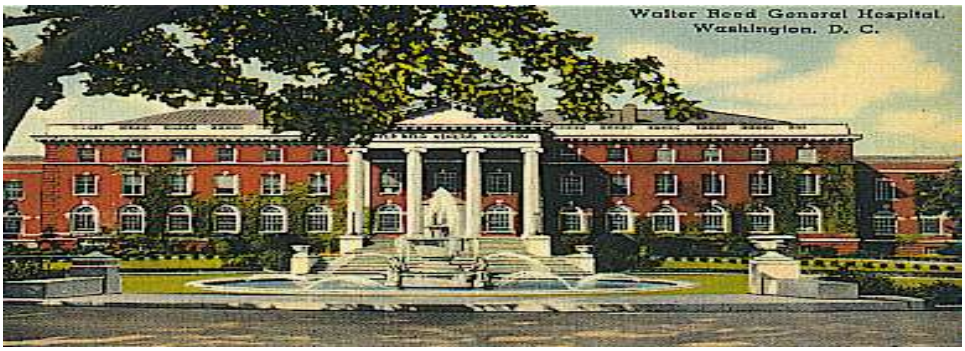
Walter Reed Cardiovascular Center



A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

Commentary
Marina N. Vernalis, DO FACC

Walter Reed Cardiology is now directly handling all inpatient transfers from outside facilities. **Page 202-356-1111 x107-3384 to speak with the Cardiology Fellow on call -24/7.** We hope this improves responsiveness, efficiency and access for all of our beneficiaries and referring providers.

Allen Taylor authored an article on *Training Cardiovascular Fellows in Cardiovascular Magnetic Resonance and Vascular Imaging* in the 2 June issue of the Journal of the American College of Cardiology as part of the Cardiovascular Training Directors Committee *. Allen's recognized international expertise in academic medicine continues to energize our program and our patient care.

As a reminder, any and all patients will be accommodated here. **Just call 202-782-3832/3833 and ask to speak with the "E-DOC" or page 202-356-1111 x107-3311.** We remain available for e-mail, phone or page consultations for all of our primary care providers throughout the NCA/NARMC. Utilize the provided contact information for patient diagnostic or treatment questions.

Our new website is available at www.wramc.amedd.army.mil
Go to Clinical Departments → Medicine → Cardiology.

*J Am Coll Cardiol 2004;43:2108-12

Cardiovascular Update
Daniel E. Simpson, MD FACC

Cardiac catheterization requires the use of radiographic contrast. As a result, contrast-induced nephropathy is a common complication. The optimal way to reduce this complication in higher risk patients continues to be controversial but the use of sodium chloride hydration is standard.

*Prevention of Contrast-Induced Nephropathy With Sodium Bicarbonate**

Background: Animal studies indicate hydration with sodium bicarbonate is more protective than sodium chloride.

Methods: Prospective, single center trial of 119 patients with a stable serum creatinine of at least 1.1 mg/dL randomized to a 154-mEq/L infusion of either sodium chloride or sodium bicarbonate before (3mL/kg x 1 hour) and after (1mL/kg x 6 hours) contrast administration. Primary endpoint was increase of creatinine ≥ 25% within 2 days.

Results: The groups were well matched. The primary endpoint occurred in 13.6% of sodium chloride patients but only 1.7% of sodium bicarbonate patients (P = 0.02).

Conclusion: Pre-procedure and post procedure hydration with sodium bicarbonate was more effective for prophylaxis against contrast-induced nephropathy.

Comments: A simple, inexpensive way to reduce this complication compared to other efforts with N-acetylcysteine or hemofiltration but additional studies in larger, more diverse patient populations is appropriate.

*JAMA. 2004;291:2328-2334. www.jama.com

Guideline Review
Daniel E. Simpson, MD FACC

The initial reports of significant valvular abnormalities associated with the use of anorectic drugs came out in the late 1990's. These medicines like "phen-phen" were removed from the market. Subsequently, more thorough study and follow-up has indicated a more benign course especially with short-term use. Periodically, we still receive consults or requests for echocardiograms concerning these patients.

*Recommendations for Patients Who Have Used Anorectic Drugs**

Class I – General agreement that procedure/treatment is useful & effective
Class II – Conflicting evidence and/or divergence of opinion
Class III – Not useful/effective and in some cases may be harmful

Class I
- Discontinuation of the anorectic drug(s)
- Cardiac physical examination

- Echocardiography in patients with symptoms, heart murmurs, or associated physical findings
- Doppler echocardiography in patients for whom cardiac auscultation cannot be performed adequately because of body habitus

Class IIa
- Repeat physical examination in 6 to 8 months for those without murmurs

Class IIb
- Echocardiography in all patients before dental procedures in the absence of symptoms, heart murmurs, or associated physical findings

Class III
- Echocardiography in all patients without heart murmurs

*ACC/AHA Task Force Report 1998

www.acc.org/clinical/statements.htm

Cardiovascular Trials at WRAMC

CARDIASTAR
PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiologyQuestions/Referrals: Please contact Daniel Simpson

OPTIMIZE-HF
Assessment of inpatients with CHF and/or LV dysfunction to determine if guideline treatment is appropriately implemented

Questions/Referrals: Please contact Stephen Welka

WARCEF
Randomized, double-blind comparison of coumadin versus aspirin for the reduction of death and stroke in heart failure patients (EF < 30% and in sinus rhythm)

Questions/Referrals: Please contact Stephen Welka

RESCUE
Randomized, open label comparison of unfractionated heparin versus low molecular weight heparin in the treatment of high-risk non-ST elevation acute coronary syndromes

Questions/Referrals: Please contact Daniel Simpson

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